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No. 94-1912

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

ROBERT C. METCALF, Director of the Department of Medical Assistance Services of the Commonwealth of Virginia,

Petitioner,

vs.

REHABILITATION ASSOCIATION OF VIRGINIA, INCORPORATED,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Do providers of health care services have an enforceable right under 42 U.S.C. § 1983 to challenge a state's failure to comply with provisions of the Medicaid Act and Medicare Act requiring states to pay Medicare "cost-sharing" amounts for services furnished to "Qualified Medicare Beneficiaries" ("QMBs")?

2. Are states required to pay Medicare cost-sharing amounts in full on behalf of QMBs?

3. Can states eliminate direct payment of the 20% Medicare coinsurance amounts to providers that furnish Medicare Part B-covered services to QMBs in nursing facilities?

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF IN OPPOSITION

Respondent Rehabilitation Association of Virginia, Incorporated[1] opposes the Director of the Virginia Department of Medical Assistance Services' Petition for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit.

In 1992, this Court denied New York State's Petition for review of the identical substantive question here presented. *New York City Health & Hosps. Corp. v. Perales*, 954 F.2d

[1] There are no parent or subsidiary companies of the Respondent to be listed pursuant to Supreme Court Rule 29.1.

854 (2d Cir.), *cert. denied*, __ U.S. __, 113 S. Ct. 461 (1992). New York's Petition for Certiorari was opposed by the co-defendant Secretary of HHS ("Secretary") on the grounds that there was not yet a conflict in the circuits and "it would be appropriate to await further litigation developments" in pending cases. Br. Opp. pp. 8-9.

Those pending cases have now been determined. The Third, Eleventh and (here) Fourth Circuits have agreed with the *Perales* decision. Petitions for rehearing have been denied in each. The Secretary has not sought review in the present case. The Petition for Certiorari should (again) be denied.

STATEMENT OF THE CASE

This case involves the elimination by the Commonwealth of Virginia, effective January 1, 1991, of the statutory rights of health care providers to receive certain Medicaid payments for services rendered to persons dually eligible for Medicare and Medicaid benefits ("dual eligibles" or "crossovers") and other "qualified medicare beneficiaries" ("QMBs"), a category of Medicare beneficiaries with income and resources below federal poverty levels.

The payments here at issue are Medicare "cost-sharing" amounts: the annual deductible and 20% coinsurance portion of the Medicare-approved reasonable costs or charges for which the Medicare-eligible patient remains personally liable. Historically, the Virginia Medicaid Program reimbursed providers for such cost-sharing amounts on behalf of dual eligibles and other QMBs. Effective January 1, 1991, Virginia amended its State Medicaid Plan so as to eliminate or drastically reduce all such Medicaid reimbursement for the Medicare cost-sharing amounts. Beginning in 1988, the Commonwealth also prohibited providers from billing the Medicaid Program directly for therapy services provided to QMBs residing in nursing facilities.

The Court of Appeals correctly held that federal law entitles providers to receive full and direct payment of the

cost-sharing amounts attributable to dual eligibles and other QMBs.

The Medicare Program

In 1965 Congress established the Medicare Program as Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395ccc. Medicare is a purely federal program which provides reimbursement for medical care to the aged and certain disabled persons.

There are two components to the Medicare Program. Part A (which is not involved in this case) provides hospital insurance benefits and is financed by Social Security payroll contributions. 42 U.S.C. §§ 1395c-1395i-4. Part B is a voluntary supplementary program for Medicare-eligibles who choose to enroll, which pays for certain physician services, hospital outpatient services, and other health services generally not covered under Part A. 42 U.S.C. § 1395j-1395w-4(j). The beneficiary is required to pay an enrollment premium and an annual deductible for services covered under Part B. Above this deductible amount, Medicare pays 80% of the "reasonable costs" in the case of services provided by a rehabilitation agency for therapy services, and 80% of the "reasonable charges" for certain other services, as those costs and charges are calculated and established pursuant to the Medicare Act and Regulations. The beneficiary is responsible for the remaining 20% coinsurance amount.

Providers are entitled to receive *full* reasonable costs and charges for *all* services provided to *all* Medicare beneficiaries. 42 U.S.C. § 1395*l*; 42 C.F.R. §§ 405.501, 410.150, 410.152. This entitlement is fulfilled through the 80% Medicare payment and the beneficiaries' payment of the "cost sharing" amounts -- the deductible and 20% coinsurance.

The Medicaid Program

Concurrently with the enactment of Medicare in 1965, Congress established the Medicaid program as Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq.*, to provide federal financial assistance to states that choose to reimburse

the costs of medical care for needy persons. To qualify for federal matching funds, states participating in the Medicaid program must have a state plan that has been approved by the Secretary as conforming with federal requirements. 42 U.S.C. §§ 1396a(a), 1396a(b).

Payment rates for services provided under the Medicaid program are established by the states and are generally not based on the "reasonable cost" or "reasonable charge" standards that govern payment under Medicare. Virginia has established Medicaid reimbursement rates that in almost all cases are lower than the "reasonable cost" or "reasonable charges" established by Medicare Part B for the same services and that are generally lower than the Medicare payment of 80% of such "reasonable cost" or "reasonable charges."

QMBs and Dually Eligible Individuals

In order to assure full and equal access to health care services and provide for full payment of Medicare reasonable costs and charges for *all* Medicare beneficiaries, Congress specifically addressed the situation of the elderly poor who could not afford the Part B enrollment premiums or pay the cost-sharing amounts.

Thus, from inception in 1965, (i) the Medicare Act permitted states to enroll the poorest of the Medicare beneficiaries — those also eligible for Medicaid — in the Part B program by entering into a "buy-in" agreement with the Secretary and paying the premiums on their behalf, and (ii) the Medicaid Act expressly required that state Medicaid programs assume crossovers' obligation to pay *all* Medicare deductibles and coinsurance amounts except that the states could elect to have a portion thereof paid by the individual on a basis reasonably related to his means. 42 U.S.C. § 1396a(a)(15) [repealed]. For services furnished to dual eligibles, the Medicaid Act (42 U.S.C. § 1396b(b)(1)) and the Secretary's Regulations (42 C.F.R. § 431.625(d)(3)) also provide that payment is to be made pursuant to the *Medicare* reasonable costs and charges rather than pursuant to the rates set under each state's Medicaid program.

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, 100 Stat. 1874) expanded this protection for the elderly poor by creating QMBs as a sub-category of Medicare beneficiaries whose incomes and resources were below federal poverty levels, but who were not poor enough to qualify for Medicaid. States were given the option to pay cost-sharing for this new QMB group under the states' Medicaid programs (thereby qualifying for federal matching funds). P.L. 99-509, § 9403(a), 100 Stat. 1874, 2053, adding subparagraph (E) to 42 U.S.C. § 1396a(a)(10).

The Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, 102 Stat. 683, made two changes concerning QMBs and cost-sharing. First, Congress made it mandatory that state Medicaid programs pay for QMBs' cost-sharing liability. P.L. 100-360, § 301(a)(1), 102 Stat. 683, 748 (amending § 1396a(a)(10)(E) to delete the phrase "at the option of a state"). Second, the definition of QMB was broadened to include all Medicare-eligible individuals with incomes below federal poverty levels, whether or not those individuals were also eligible for Medicaid. *See* § 8434(a) of the Technical and Miscellaneous Revenue Act of 1988, P.L. 100-647, 102 Stat. 3342, 3805. This broadened definition rendered the crossover provision -- § 1396a(a)(15) -- unnecessary, and it was repealed effective July 1, 1989.[2] Thus, the obligation of states to pay Medicare cost-sharing in full was continued and made uniform for dual eligibles and other QMBs through § 1396a(a)(10)(E) ("§ (a)(10)(E)"), discussed below (pp. 17-18, *infra*).[3]

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[2] *See* P.L. 100-360, § 301(e)(2)(C), 102 Stat. 683, 749, as amended by § 608(d)(14)(I) of the Family Support Act of 1988, P.L. 100-485, 102 Stat. 2343, 2416.

[3] The QMB coverage provisions were initially made optional, rather than mandatory, because "the Committee recognizes that the fiscal constraints facing many states may preclude" more comprehensive coverage. H.R. Rep. No. 727, 99th Cong., 2d Sess., *reprinted in* 1986 U.S. Code Cong. & Ad. News 3607, 3696. The cost-sharing option was made mandatory two years later, notwithstanding these fiscal constraints.

The Medicare cost-sharing that § (a)(10)(E) requires the states to pay on behalf of QMBs is defined (in 42 U.S.C. § 1396d(p)(3)) ("§ d(p)(3)") as including all Medicare Part B premiums, coinsurance, and deductibles. Cost-sharing is specifically defined (§ d(p)(3)(D)) (Pet. App. 116) to include

> "the difference between the amount that is paid under section 1395*l*(a) of this title [*i.e.*, 80% of the reasonable costs and charges for covered Part B services] and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent.' "

The statute thus specifies payment of "the difference between" 80% and 100% of Medicare reasonable costs and no amount of deference can convert the statutory text into the "difference between 80% and a state's Medicaid rate."

The Virginia Restrictions

In accordance with these requirements, until January 1, 1991, Virginia paid the full cost-sharing amounts on behalf of dual eligibles and other QMBs. Effective January 1, 1991, Virginia amended its State Medicaid Plan (approved by the Secretary) to reduce or eliminate Medicaid payments of cost-sharing amounts for Medicare Part B services. As it relates to this action, the Amendment permits payment by the Virginia Medicaid program of QMBs' Medicare Part B cost-sharing obligations only to the extent that the amount paid by the Commonwealth plus the 80% Medicare payment of the reasonable cost or charge, does not exceed the level of reimbursement established by the Medicaid fee schedule. For many Part B services, the 80% Medicare payment exceeds the corresponding Medicaid rate for the service. Thus, in many cases the Commonwealth now pays no part of the Part B cost-sharing amounts.

In addition to this "Medicaid rate limitation," Virginia adopted a series of Medicaid State Plan Amendments (approved by the Secretary), beginning in 1988, which prohibit providers of therapy services from submitting separate

claims to the Virginia Medicaid program for services furnished to Medicaid patients in nursing facilities.

These "direct billing" Amendments, which on their face do not refer to dual eligibles or other QMBs, are uncontroverted to the extent that they prohibit the submission of separate *Medicaid* claims for therapy services furnished to "pure" *Medicaid* patients (*i.e.*, those who are not also Medicare-eligible) in nursing facilities. What the Association challenged in this action was the application of the Amendments so as to eliminate payment of *Medicare Part B* cost-sharing to rehabilitation agencies for therapy services furnished to QMBs. Virginia refused to pay the 20% coinsurance amounts to the rehabilitation agencies notwithstanding their receipt of the 80% payment directly from Medicare.

The Decision Below

The Court of Appeals for the Fourth Circuit held (42 F.3d 1444; Pet. App. 1-71) that the Medicaid Act requires states to pay the full Medicare cost-sharing amounts on behalf of dual eligibles and other QMBs, and that such cost-sharing must be paid directly to the rehabilitation agencies that receive the 80% Medicare payment for services furnished to QMBs in nursing facilities. The Court thus invalidated the Virginia Plan Amendments that eliminated providers' right to direct and full payment of such cost-sharing amounts. Because it found the statutes to be unambiguous and complete on the specific issues presented, it refused to defer to the Secretary's contrary position. (42 F.3d at 1450-58; Pet. App. 15-34.) Virginia's petition for rehearing and suggestion for rehearing *en banc*, which set forth all of the arguments here presented, was denied. (Pet. App. 72.)

REASONS FOR DENYING THE WRIT

This case presents none of the requisite "special and important reasons" (Sup. Ct. Rule 10) for granting a Petition for Certiorari. There is unanimity, not a conflict, among the four Courts of Appeals that have addressed the substantive issue; there has been no "depart[ure] from the usual course of

judicial proceedings"; no federal question has been decided in a way that conflicts with decisions of this Court; and no question of federal law is presently at stake "that should be settled by this Court." *Id.* Moreover, the Secretary, whose approval of New York's identical regulation was invalidated by the Second Circuit, opposed *certiorari* in *Perales*, and she has neither petitioned for *certiorari* here nor submitted a brief in support of Virginia's Petition, as permitted by Supreme Court Rule 12.4.

A. The Divided "Federal Judiciary" and the *Chevron* Standard

The Petition suggests several "special and important" reasons warranting review, the first of which is the supposed considerable dissension in "the federal judiciary" (Pet. 10), which creates uncertainty for the states that rely on the Secretary's interpretation at their peril. (*Id.* 18, 24.)

The "sharply divided federal judiciary," to which reference is made (*id.* 20), is principally between the rejected view of three District Courts, on the one hand, and four Courts of Appeals on the other. There is no divergence of views reflected in the holdings or extensive analysis in *New York City Health & Hosps. Corp. v. Perales*, *supra*, 954 F.2d 854; *Pennsylvania Med. Soc'y v. Snider*, 29 F.3d 886 (3d Cir. 1994); *Haynes Ambulance Serv. Inc. v. Alabama*, 36 F.3d 1074 (11th Cir. 1994), and the Fourth Circuit decision herein. Petitions for rehearing have been denied in each of the four Circuits.

As to the dissenting opinions, Judge Cardamone's rationale in *Perales* (full payment is mandatory for Part A, but not Part B coinsurance) has not only previously been found to be an insufficient basis for *certiorari*, but has subsequently been abandoned by the Secretary and is not here relied on by Virginia (pp. 11n.5, 16-17n.7, *infra*). Judge Niemeyer's dissent herein was based on what he believed to be an ambiguity in the statutes as they existed between 1986 and 1988 and as they relate to the relatively small group of "pure QMBs," *i.e.*, those not dually eligible. As shown below, the dissent's analysis violates basic principles of statutory construction,

which is why it has been rejected by all of the Circuit Courts (pp. 17-18, *infra*).

None of the cases represents any departure from the established standards governing deference to administrative agency interpretations. Each of the cases applied, and answered, the first question posed in *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842-43 (1984): Is "the statute silent or ambiguous with respect to the specific issue?" Each Court found unmistakable Congressional intent, based on the statutory language and (if necessary) contemporaneous legislative history that states must pay the Medicare cost-sharing amounts in full. *See Perales*, 954 F.2d at 861 ("we do not believe the Medicare and Medicaid statutes are [ambiguous or silent] with respect to the question before us"); *Snider*, 29 F.3d at 902 ("there is in fact no ambiguity as to how much states have to pay"); *Haynes*, 36 F.3d at 1077 ("we reject [defendants'] attempts to wring ambiguity from a statute where there is none"); *Rehabilitation Ass'n* (42 F.3d at 1458; Pet. App. 34) (finding "clear Congressional intent that state co-payments under the buy-in program for [QMBs] be . . . complete").

Petitioner argues for a modification of the *Chevron* standard when (i) the issue is "complex," (ii) involves welfare administration, (iii) has major financial ramifications, and (iv) a state agrees with the agency's interpretation. (Pet. 16-18). Whatever the merits of such an argument as to *Chevron*'s second inquiry -- the reasonableness of the agency's interpretation -- such factors have no bearing on whether Congress has spoken directly and unambiguously as to the precise question in issue.

As to complexity, Judge Feinberg correctly concluded in *Perales* (954 F.2d at 862-63):

> "When faced with a complicated statutory scheme, there is a strong temptation for judges to assume that the scheme has no fixed meaning or purpose and simply to defer to the interpretation given the statutory text by an administrative agency.

> In a society as complex as ours, many statutes are of necessity complicated. However, complexity is not the same as ambiguity. Congress passes legislation with specific purposes in mind. When the ordinary tools of statutory construction permit us to do so, we must attempt to discover those purposes from the text, structure and history of the acts in question. Sometimes we will find that Congress has not addressed the problem posed by a particular case. In such circumstances, we are required to defer to administrative expertise. But where we confront a statute that evinces a legislative purpose clearly at odds with the proffered administrative interpretation, we should not defer. Indeed, our constitutional duty to interpret the law requires us to effectuate the legislative intent notwithstanding the contrary administrative view."

See Snider, 29 F.3d at 902 ("complexity alone is not enough to trigger *Chevron*"); *Haynes*, 36 F.3d at 1076 (following *Snider*); *Rehabilitation Ass'n*, 42 F.3d at 1450; Pet. App. 13 (*Chevron* "did not replace Article III of the Constitution").

Nor is there any occasion to abandon *Chevron* in matters causing significant state expenditures in welfare programs.[4] Congress can speak, and here has spoken, with equal directness

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[4] Virginia's obligation to pay "astronomical sums" as a result of the decision (Pet. 18) is irrelevant. Indeed, from the inception of the Medicare and Medicaid programs in 1965 until January 1991, Virginia paid the Medicare cost-sharing *in full*. The decision simply restores the *status quo ante* by restoring the pre-1991 policy. Virginia relies on the Medicaid Act's general statement of legislative purpose to provide medical assistance "as far as practicable" under state conditions (42 U.S.C. § 1396). But that provision has never been held to excuse compliance with mandatory federal requirements. *See, e.g.*, *West Virginia Univ. Hosp. v. Casey*, 885 F.2d 11, 23-24 (3d Cir. 1989) ("budgetary constraints . . . [cannot] excuse a failure to conform to" federal standards), *aff'd*, 499 U.S. 83 (1991); *AMISUB (PSL), Inc. v. Colorado Dep't of Social Services*, 879 F.2d 789, 800 (10th Cir. 1989) ("budgetary constraints cannot excuse noncompliance with federal Medicaid law"), *cert. denied*, 496 U.S. 935 (1990).

and clarity in such areas, as in any other. And Virginia's "agreement" with the Secretary's position is wholly irrelevant: it is only the views of the agency charged with the administration of the particular statute that is of any moment. *See Nationsbank of North Carolina, N.A. v. Variable Annuity Life Ins. Co.*, __ U.S. __, 115 S. Ct. 810, 813 (1995). Moreover, where, as here, the interpretation shifts from case to case, those views are "entitled to considerably less deference." *Thomas Jefferson Univ. v. Shalala*, __ U.S. __, 114 S. Ct. 2381, 2388 (1994), quoting *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987); *see Perales*, 954 F.2d at 861-62 ("The expertise in statutory interpretation to which we normally defer becomes dubious when the expert cannot make up its own mind"); *Snider*, 29 F.3d at 902.[5]

Finally, Virginia invokes policy considerations in support of the Petition. It is urged (Pet. 10) that, in general, the decision below is a precursor to federal courts displacing executive agencies in determining reimbursement to providers and, specifically, a decision by this Court would provide "guidance" to the states and Congress in future debates as to health care policy. First, and obviously, this argument misperceives the respective roles of the players. Neither the courts nor the agencies establish the requirements for reimbursement. Congress does so in legislation. When the Secretary or states act

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[5] Judge Cardamone's dissent in *Perales* concluded that Congress "explicitly command[ed]" that states pay *Part A*, but not Part B, coinsurance in full. 954 F.2d at 865-67. The Secretary advised the Eleventh Circuit that Judge Cardamone correctly "endorsed the Secretary's position," but because no such Part A/Part B distinction exists (*see Haynes*, 36 F.3d at 1077 n.1), the Secretary abandoned that position in the District Court below, acknowledging that there were *no* differences between Part A and Part B cost-sharing: the states need not pay either. On appeal, the Secretary returned to embrace the *Perales* dissent as correctly distinguishing Part B payments as permissive, which was again rejected. 42 F.3d at 1452; Pet. App. 18-20. Similarly, the Secretary changed position as to whether the beneficiary could be charged if the states do not pay. *Perales*, 954 F.2d at 861-62; *Snider*, 29 F.3d at 902-03; *see Rehabilitation Ass'n*, 42 F.3d at 1459 n.12; Pet. App. 37 n.12.

contrary to the statutory command, courts intervene to ensure compliance and, in so doing, will defer to the agency's expertise when there is a need " 'to fill any gap left, implicitly or explicitly, by Congress.' " *Chevron*, 467 U.S. at 843, quoting *Morton v. Ruiz*, 415 U.S. 199, 231 (1974).

Moreover, it is plainly not the function of this Court to provide future "guidance" to Congress as to what it should do in the health care or any other field. At most, there can be only an interpretation and enforcement (if constitutional) of what it has done in the past. And if the states need guidance here, they need look no further than the decisions of the four Courts of Appeals or even the unambiguous statutory words themselves: payment in full of the difference between 80% and 100% of Medicare reasonable costs. Virginia had no difficulty in understanding its statutory obligation prior to 1991 when it paid in full.

Before turning to the substantive issue presented, we first address Virginia's assertion that providers do not have a right of action to sue.

B. Plaintiff Has an Enforceable Right Under 42 U.S.C. § 1983 to Challenge Virginia's Refusal to Pay Medicare Cost-Sharing

No substantial question is presented by Virginia's petition concerning providers' standing to challenge, under 42 U.S.C. § 1983, Virginia's payment restrictions. The right that Plaintiff seeks to enforce is the right to state payment of Medicare cost-sharing required by §§ (a)(10)(E) and d(p)(3). That right clearly is enforceable under § 1983, as the Court below correctly and unanimously concluded. 42 F.3d at 1449-50, 1462; Pet. App. 12, 44.

Section 1983 provides a cause of action for " 'the deprivation of any rights, privileges, or immunities secured by the Constitution and laws of' the United States." *Wilder v.*

Virginia Hosp. Ass'n, 496 U.S. 498, 508 (1990).[6] Whether a particular statute creates a right enforceable under § 1983 turns on whether "the provision in question was intend[ed] to benefit the putative plaintiff." *Id.* at 509. If so, the statute creates an enforceable right unless it reflects merely a "congressional preference" for a certain kind of conduct rather than a binding obligation on the governmental unit, or unless the interest is " 'too vague and amorphous' such that it is 'beyond the competence of the judiciary to enforce.' " *Id.*, quoting *Wright v. Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418, 431-32. *See also Livadas v. Bradshaw*, __ U.S. __, 114 S. Ct. 2068 (1994); *Suter v. Artist M.*, 503 U.S. 347 (1992).

Virginia does not argue, nor could it, that the statutes here at issue -- which provide that states "must" pay Medicare cost-sharing, including the difference between "80 percent" and "100 percent" for Part B services -- are not binding on the states or that they are too vague or amorphous to be enforceable by the judiciary. Rather, Virginia asserts that the QMB provisions were not intended to benefit providers. There is no merit to Virginia's assertion.

In *Wilder*, this Court held that "there can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment" -- the Medicaid Act provision (42 U.S.C. § 1396a(a)(13)(A)) requiring that Medicaid payment for hospital services be "reasonable and adequate to meet the costs of" efficient hospitals. 496 U.S. at 510. But *Wilder* makes clear that its holding is not limited to provider challenges brought under the Boren Amendment: the Court found that "Congress and the States both understood *the [Medicaid] Act* to grant health care providers enforceable rights". *Id.* at 518 (emphasis added). The Court found that providers were intended

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[6] Virginia's reliance on *Cort v. Ash*, 422 U.S. 66 (1975) is clearly misplaced. *Cort* did not involve the question of enforceable rights under § 1983, but rather, the question whether a private right of action can be *implied* from a particular statute -- "a different inquiry" than whether a statute creates an enforceable right under § 1983. *Wilder*, 496 U.S. 498, 508 n.9.

beneficiaries of the Boren Amendment because that Amendment "establishes a system for reimbursement of providers" and is "phrased in terms benefitting health care providers: It requires a state plan to provide for '*payment . . . of*' " certain specified services. *Id.* at 510 (emphasis added).

The provisions at issue here are part of that same "system of reimbursement": both the Boren Amendment (§ (a)(13)(A)) and the QMB cost-sharing provision (§ (a)(10)(E)) are subsections of § 1396a, which sets forth the requirements that state plans "must" satisfy. Section (a)(10)(E) provides that states "must" make "medical assistance" -- defined as "*payment* of" the cost of medical care and services (42 U.S.C. § 1396d(a)) -- "available for medicare cost-sharing" (emphasis added). Thus, just as providers have enforceable rights under § 1983 to challenge the adequacy of Medicaid rates under § (a)(13)(A), providers have enforceable rights to challenge a state's refusal to pay the Medicare cost-sharing mandated by § (a)(10)(E).

Virginia seeks to distinguish the Boren Amendment at issue in *Wilder* from § (a)(10)(E) by asserting that (i) the former, but not the latter, refers specifically to services furnished by *facilities*, and (ii) "the focus" of the QMB provisions is "on the beneficiaries" rather than providers (Pet. 14-15). These so-called distinctions are of no consequence.

First, the reason that the Boren Amendment refers specifically to facilities is because Congress intended the Boren requirements to apply only to inpatient services furnished by certain types of facilities, *e.g.*, inpatient hospital services (*see State of New York v. Bowen*, 811 F.2d 776 (2d Cir. 1987)). Section (a)(10)(E), however, is not so limited, and requires states to pay Medicare cost-sharing for *all* Medicare-covered services without distinction.

Second, that Congress "focused on" QMBs and intended them to have the benefit of Medicare-covered services is clear. But it also is clear that Congress sought to protect QMBs by requiring states to pay QMBs' Medicare cost-sharing in full. "A guarantee of reimbursement, by protecting

providers, protects patients" -- which is equally true for § (a)(13)(A) and § (a)(10)(E). *Perales*, 954 F.2d at 861. Moreover, the "medicare cost-sharing" that states "must" pay pursuant to § (a)(10)(E) is defined as "*costs incurred* with respect to a [QMB]." § 1396d(p)(3) (emphasis added). It is, of course, *providers* that "incur costs" in furnishing services to QMBs.

Finally, Virginia misleadingly characterizes the issue presented as whether *Wilder* will be "dramatically expanded, so that health care providers *not* covered by the Boren Amendment will nevertheless be able to challenge the reimbursement rates of a state Medicaid plan in federal court." (Pet. 11, emphasis in original.) But this case does not involve a challenge to the adequacy of, or states' authority to establish, *Medicaid rates*; the issue here is whether states are required to pay the 20% coinsurance portion of the *federally*-established *Medicare* rates for services furnished to QMBs. Contrary to Virginia's assertion, the statutory provisions requiring state payment of *Medicare* cost-sharing amounts are in no way related to a state's authority to set *Medicaid* rates for covered Medicaid services. No latitude whatsoever is granted with respect to the former.

Far from dramatically expanding the scope of § 1983, the present case does not even raise the objections voiced in the *Wilder* dissent. There is no question analogous to whether the Boren requirements are procedural or substantive (496 U.S. at 527-28): the command of § (a)(10)(E) is clear. And the issue here is not confined to Medicaid state plan requirements (*id.* at 527), but is intertwined with providers' established rights under the Medicare Act.

Under the Medicare Act, a provider of covered services is entitled to recover 100% of the Medicare-determined reasonable costs or charges: 80% from the Medicare program (§ 1395*l*) and 20% from the beneficiary: the Medicare Act expressly accords providers the right to bill beneficiaries for the cost-sharing amounts (*see* 42 U.S.C. § 1395cc(a)(2)(A) ("A provider of services *may charge such*

individual or other person" the deductible and 20% coinsurance amount) (emphasis added)). *See also* 42 C.F.R. § 424.55(a) and (b)(2)(ii). Because (i) the beneficiary cannot be charged beyond a nominal portion of the cost-sharing amount (*see* 42 U.S.C. §§ 1396a(a)(14), 1396*o*), and (ii) states are required to "stand in the shoes of QMBs" (*Snider*, 29 F.3d at 892) and pay the cost-sharing on the beneficiaries' behalf, Virginia's payment limitation violates the Medicare Act as well as the Medicaid Act. *Perales*, 954 F.2d at 858-59; *Snider*, 29 F.3d at 891-92. The Respondent Association has standing to challenge violations of both statutes.

C. Congress Was Not Silent or Ambiguous on the Precise Question in Issue

In an attempt to create an ambiguity justifying deference, Virginia relies on § 1396a(n) (states "may" exceed the Medicaid rate in paying the coinsurance amounts) and post-enactment legislative "history" (subsequent House Committee Reports noting the "practice" of some states not to make full payment).

All of these arguments, and others, were made and rejected in *Perales*. They were made in support of New York's Certiorari Petition and found insufficient. They were then made in *Snider*, *Haynes* and *Rehabilitation Ass'n* -- and were rejected. Common to the four Circuit Court opinions is not only the result, but the exhaustive analysis undertaken by each. The decisions are clearly correct.

(i) There is unanimity that for the 20 years prior to the 1986 QMB amendments, states were required to pay Part A *and* Part B cost-sharing in full for dual eligibles. All of the contemporaneous legislative history is in accord. *Rehabilitation Ass'n*, 42 F.3d at 1451-52, 1458; Pet. App. 15-20, 34; *Snider*, 29 F.3d at 897.[7]

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[7] Judge Cardamone's conclusion that only Part A "must" be paid ignored the statutory language, and was based on only a part of the legislative history. Because § 1396a(n) applies to both Part A and Part B (*see*

(Footnote continued)

(ii) In 1986, Congress sought to *broaden* the protected class by creating QMBs (elderly poor but ineligible for Medicaid). It did not, at the same time, destroy the protection for dual eligibles and the new QMB group by making the mandatory cost-sharing payments permissive.

(iii) The 1986 QMB Amendments provided that states opting to cover QMBs "must" pay all Medicare cost-sharing (§ (a)(10) (E)), specifically defined to include "the difference between" the 80% Medicare payment and the 100% Medicare reasonable cost (§ d(p)(3)(D)). The Circuit Courts were obviously correct in rejecting the argument that Congress was "silent" as to how much of the 20% must be paid. *Snider*, 29 F.3d at 896; *Rehabilitation Ass'n*, 42 F.3d at 1453, 1455; Pet. App. 22, 27.[8]

Nor is ambiguity created by the simultaneous addition of § 1396a(n), providing that the coinsurance payments "may" exceed the Medicaid rate. The problem with the Secretary's interpretation ("may, but need not"), and Judge Niemeyer's dissenting conclusion that deference is appropriate, is that it reads the mandatory §§ (a)(10)(E) and (d)(p)(3) completely out of the statute. " 'Statutory construction is a holistic endeavor . . . and, at a minimum, must account for a statute's full text, language as well as punctuation, structure, and subject matter.' " *Snider*, 29 F.3d at 895, quoting *United States*

Haynes, 36 F.3d at 1077 n.1), the Secretary has abandoned the rationale of Judge Cardamone's dissent. Strangely, Virginia continues to cite that opinion and the three District Courts that have followed it (and that have been reversed) as evidence of the "considerable dissension" in the federal judiciary. (Pet. 10.)

[8] Virginia's reliance (Pet. 6) on the definition of "medical assistance" in § 1396d(a) ("payment of part or all of the cost" of covered services) is misplaced. The reference there to "part or all" merely recognizes that states were permitted under former § 1396a(a)(15), and are now permitted under § 1396*o*, to offload some nominal portion of their obligation to pay the cost-sharing amounts on the dual eligibles/QMBs, thereby paying only a "part of" such amounts. *See Rehabilitation Ass'n*, 42 F.3d at 1451-52, 1454-55, 1459; Pet. App. 16-18, 25-26, 36.

Nat'l Bank of Oregon v. Independent Ins. Agents of Am., Inc., __ U.S. __, __, 113 S. Ct. 2173, 2182 (1993). As the Courts of Appeals concluded, there is no conflict between the statutory provisions because they can be read harmoniously: the states "must" pay the coinsurance in full and "may" exceed the Medicaid rate in so doing.[9]

If resort to legislative history is necessary, *all* of the 1986 contemporaneous legislative history fully supports the view that the coinsurance must be paid in full for the new QMB group, just as such payments were mandatory for dual eligibles for the past 20 years. *Rehabilitation Ass'n*, 42 F.3d at 1455; Pet. App. 26-27; *Snider*, 29 F.3d at 894, 896, 899.

(iv) In 1988, Congress made coverage of the new QMB group mandatory (by deleting the phrase "at the option of a State" from § (a)(10)(E)). Although no change was made in the amount of the cost-sharing that states must pay, Petitioner relies (Pet. 6-8) on 1988 and 1989 House Reports that acknowledge the "practice" of states to limit payment by application of their Medicaid rates. Applying the established precedents of this Court, each of the Circuit Courts rejected reliance on the oxymoronic "post-enactment legislative

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[9] The purpose of § 1396a(n) was to clarify that other limitations in the Medicaid Act that proscribed payment in excess of the Medicaid rate did not apply in the case of coinsurance payments. *Perales*, 954 F.2d at 859; *Snider*, 29 F.3d at 895. Contrary to the position of the dissent herein (42 F.3d at 1465-70; Pet. App. 53-67) and the majority's view that this interpretation of § a(n) is not "particularly satisfying" (*id.* at 1454; Pet. App. 24), this clarification *was* necessary: in 1983, a District Court ruled that dual eligibles were primarily Medicaid patients as to whom the Medicaid rate limitations applied. *Samuel v. California Dep't of Health Services*, 570 F. Supp. 566, *amended*, 572 F. Supp. 273 (N.D. Cal. 1983). Moreover, both Virginia and the Secretary acknowledged to the District Court below that § a(n) created an exception to the Medicaid Act provisions limiting states' payments to their Medicaid rates. In any event, the dispute between the majority and minority views below was confined to the statutory provisions in effect between 1986 and 1988, and applied only to the "pure QMBs," those not also dually eligible. Today, there is no ambiguity in the statute as to all QMBs, including dual eligibles.

history." *Rehabilitation Ass'n*, 42 F.3d at 1457-58, Pet. App. 31-34; *Snider*, 29 F.3d at 899 ("the 1988 reporting committee did not draft the provisions relating to the scope of payment"); *Perales*, 954 F.2d at 861; *Haynes*, 36 F.3d at 1076 (following *Snider*). As the Court below concluded, "the only honest way to change the law is to actually change the law, not to drop contrary language into committee reports addressing totally unrelated provisions." 42 F.3d at 1458; Pet. App. 34. These decisions are entirely correct and the subsequent legislative "history" cannot be used to effect a "wrenching change to a statute's meaning that had been stable for 20 years." *Id.* at 1457; Pet. App. 31.

(v) Finally, Petitioner suggests (Pet. 21-22) that the Fourth Circuit made an inappropriate policy choice in concluding that reimbursement for QMBs should be at the Medicare rate -- *i.e.*, that age, not poverty, is determinative -- particularly in the absence of "evidence" that QMBs would receive inadequate care if the lower Medicaid rates applied. As the Court below concluded, whether age or poverty should be determinative is a choice "we are not called upon to make. . . . Congress intended to provide maximum protection to the population of Americans 65 years of age or older . . . . [T]here can be no doubt but that the QMB is a Medicare enrollee, and that payment must be made at the Medicare rate." (*Id.* at 1459; Pet. App. 38.) "Evidence" that this protection is unnecessary should be addressed to Congress, not to the courts.

Nor should *certiorari* be granted because of the "additional disruption" (Pet. 19) said to result from the Fourth Circuit's decision that Virginia must pay the 20% Medicare coinsurance for therapy services furnished to QMBs in nursing facilities *directly* to rehabilitation agencies -- the same providers that receive the 80% Medicare payment.[10] Virginia's

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[10] Although Virginia maintains that therapy costs are reimbursed through the nursing facility rates (Pet. 8-9), in fact the nursing facilities have no such costs to report because they do not pay the rehabilitation agencies. That refusal to pay is understandable because such payments would never be reimbursed: the nursing facility costs would often exceed the cost

(Footnote continued)

prohibition on direct billing by therapy providers for services furnished to "pure" *Medicaid* patients in nursing facilities -- those who are not also eligible for Medicare -- is here uncontroverted. Thus, whatever the billing limitations under the Virginia Medicaid program as to pure Medicaid patients, under the federal Medicare program rehabilitation agencies are entitled to direct payment of the 80% Medicare payment for such services -- notwithstanding the Virginia *Medicaid* direct billing restriction. And having received such 80% Medicare payment, the rehabilitation agency clearly is entitled to receive the 20% coinsurance from the Commonwealth. 42 F.3d at 1460-62; Pet. App. 39-44. Virginia's obligation to pay the coinsurance cannot be discharged by paying a third party -- the nursing facility -- which is under no obligation to pay, and does not pay, the Medicare provider of covered Medicare services to Medicare patients -- the QMBs.

"ceiling" and, in any event, no payment would be received until the "rate year," two years after the cost-reporting period. Virginia's obligation to pay the coinsurance thus magically disappears.

CONCLUSION

For the foregoing reasons, Respondent Rehabilitation Association of Virginia, Incorporated respectfully submits that the Petition for a Writ of Certiorari should be denied.

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